Instructions for Completing the Serious Preventable Adverse Event Root Cause Analysis (RCA) Form

The *Report of Serious Preventable Adverse Event in A New Jersey General Hospital: Root Cause Analysis (RCA) Form* must be completed by the hospital for each serious preventable adverse event reported to the Department. The completed *RCA form*, with any supporting documentation, must be received by the Department **no later than 45 days following the date of submission of the initial report to the Department.** Information should be sent to:

Patient Safety Reporting Initiative
Health Care Quality Assessment
New Jersey Department of Health and Senior Services
25 Scotch Road, Suite 10
Ewing, NJ 08628

RCA Team Requirements

The RCA is to be performed by a multi-disciplinary team of the hospital or the system to which the hospital belongs. It is to be submitted in the format described below.

RCA Process Requirements

The RCA process consists of three components: Facts of the Event, Causality, and Action Plan. All of these components must be included for the RCA to be considered acceptable. The components are defined as:

Facts of the Event

a. Provide specific details of the event including the date, time, and day of the week;

b. Where the event occurred;

c. Describe the elements of the event clearly and in chronological order. Identify all staff involved by title and function. Give enough detail that a person not familiar with the event can understand what happened;

d. Describe the adverse event and how the patient was affected;

e. Did a similar event occur in the past three years in this facility? If yes, state when it occurred and describe what corrective actions, if any, were implemented.

Causality

a. Using the *Rules of Causation* guidelines attached (see Appendix), describe all the direct causes of the event and all procedural or systemic causes that contributed to the event's occurrence.

Action Plan

a. Describe the corrective actions that the facility will implement to prevent a similar incident from occurring in the future. These actions should be specific and address each cause listed (i.e., someone who is not a member of the RCA team should be able to understand what to do next);

b. Describe the time frame for implementation of each corrective action;

c. Describe how each corrective action's effectiveness will be measured and monitored.

Purpose of the RCA

The purpose of the RCA is to uncover the factor(s) that led to and caused a serious preventable adverse event. It is not intended to assign blame to individuals or to organizations. Prior research has shown that most adverse events are due to systemic failures rather than intentional individual acts or professional incompetence. Only by determining the underlying systemic causes of an adverse event can an effective action plan be formulated to minimize the chances of reoccurrence.

For Example:

Patient A received the wrong medication, which led to a reaction, which required medical intervention and a prolonged hospitalization.

In analyzing the event, an investigator not familiar with RCA determined that the cause was, "The nurse was tired and grabbed the wrong medication by mistake." The investigator then recommended that the nurse be counseled not to come to work tired.

This approach, however, does not address any systemic causes. A more appropriate analysis using RCA might find that there had been a flu outbreak and that the nurse had worked three double shifts that week. The analysis might also note that two medications with almost identical packaging were involved and that one of the lights in the nursing station had been out for over a week making it more difficult to read the label. In light of these additional factors, a more effective action plan could be formulated to address all the causes contributing to the adverse event.

In performing the RCA and formulating the corrective action plan, the RCA Team should draw on such resources as evidence-based medicine literature, best-practices reports, Joint Commission Resources (a not-for-profit subsidiary of the Joint Commission on the Accreditation of Healthcare Organizations), or other resources, if appropriate.

COMPLETING THE FORM

Please Type or Print All Information

SECTION A – GENERAL INFORMATION

1. Facility Identification

- List facility name, full address, and State of NJ license number.
- List the name, title, and contact information of the person completing the form.

SECTION B –INCIDENT INFORMATION

2. Description of the Event

- List the date and time of the event (note: if the event involves a surgical procedure, indicate the time that the procedure began).
- If the time of the event is unknown, list the time as "unknown."
- List the patient's medical record number, billing number (if appropriate), and full name.

SECTION C –ROOT CAUSE ANALYSIS

3. Select Root Cause

- Indicate from your analysis of the direct, procedural, and systemic causes of the adverse event the specific processes involved as contributing factors.

4. What Were the Contributing Factors to the Event?

- Indicate from your analysis of the direct, procedural, and systemic causes of the adverse event if any of the listed activities or characteristics were contributing factors.

5. Evaluate Impact of Event for Patient

- Review the impact of the event for the patient (check all that apply).

6. Describe Root Cause Analysis

- Provide a comprehensive description of the analysis process and findings, including specific actions for implementation, time frame for implementation, and measurement and monitoring goals for evaluating the effectiveness of the planned intervention. Note any specific recommendations from the Patient Safety Committee.
- Describe the facts of the event, causality, and action plan as described under *RCA Process Requirements* on page 1 of this chapter.
- List any reports to other organizations or agencies (e.g., equipment manufacturers, pharmaceutical manufacturers and professional oversight boards) concerning this event.